Under no circumstances shall the annual weighted average increase in cost within any peer group driven by this calculation exceed a 7% limit.

C. On the third year (July, 1993) rates shall be calculated based upon the audited cost reports available for each facility for FYE 12/31/90. If the audited cost data show that the annual inflators were too high, or if they show the inflators were too low, the actual cost from the reports available for FYE 12/31/90 shall be used. There shall be NO retrospective changes to the rates if/when the "third year" rebased rates show that the 7% annual inflator was inaccurate.

D. Beginning July, 1993, rates shall be recalculated or rebased every third year and the annual inflator shall be used to increase the rates in the interim years.

E. In rebasing years, the initial base rate for pediatric specialty hospitals will be attributed to the routine, ancillary, capital, and medical education cost centers, proportionally, based on the actual costs from the most recently audited cost report. The cost per discharge for the medical education cost center, which is capped at 100 percent, will be deducted from the initial base rate and the remainder will be attributed to the other three costs centers in proportion to actual costs. These figures, which will add up to the total base rate, will represent the pediatric specialty hospital peer group caps for the routine, ancillary, and capital cost centers. These figures will be used as the starting point for subsequent payment cap adjustments as described in the previous definition of Base Rate.

3. Effective for dates of service after July 1, 1991, exempt hospitals will receive annual modifications to per diem rates. Based on hospital-specific annual projected inpatient cost increases and changes in consumer price index, per diem rate increases or decreases will be authorized subject of a maximum increase of 7% annual limit. Beginning in July, 1993, and for future PPS hospital rebasing periods, the maximum amount of any cost increase granted to an exempt facility's per diem rate shall be no more than the weighted average increase in the base rates of participating PPS hospitals. This exemption from the 7% annual limit shall be in effect only for the State fiscal year 1994 and for every year thereafter when PPS hospital base rates are recalculated. In no case, shall the per diem rate granted to an exempt hospital exceed the facility's Medicaid cost per day.

4. Exempt hospitals are eligible for the Major Teaching Hospital and Disproportionate Share Payments.

5. Non-emergent inpatient medical care rendered at an out-of-state hospital to a Colorado Medicaid patient must be prior authorized by the Department, based upon review and recommendation by the Peer Review Organization (PRO).

6. Payment for out-of-state and non-participating Colorado Hospital inpatient services shall be at a rate equal to 90% of the average Colorado Other Urban or Rural DRG payment rate. Out-of State urban hospitals are those hospitals located within the Metropolitan Statistical Areas (MSA) as designated by the U.S. Department of Health and Human Services.

7. Effective January 1, 1992: When needed inpatient transplant services are not available at a Colorado Hospital, payment can be made at a higher rate (than 90% of the average Colorado Other Urban or Rural DRG payment rate) for non-emergent services if the provider chooses this payment method. When not reimbursed at a DRG payment rate the out-of-state hospital will be paid based upon the following criteria:

   a. Payment shall be 100% of audited Medicaid costs.

   b. In no case shall payment exceed $1,000,000 per admission.

8. All hospitals participating in the Medicaid program will submit Medicaid and total hospital utilization, statistical, and financial data to the Colorado Hospital Association Date Bank Program. If a hospital does not report to the Colorado Hospital Association Data Bank, the State agency will send the required format for reporting this data.

**Free Standing Psychiatric Hospitals (Excluding State Institutions):**

1. Effective October 10, 1988, new payment rates for care provided to Medicaid patients under 21 in Cedar Springs Psychiatric Hospital, Centennial Peaks Hospital, and Cleo Wallace Center have been established. The Department analyzed historical Medicaid payment rate data and evaluated the nature of the relationship between hospital cost data and patient length of stay information. Fiscal Year 1987 Medicaid cost data from the participating facilities was used to determine the break points within the 42 day average length of stay, where costs differ substantially. This 1987 data revealed that costs for the first seven days of care were 38% higher than costs for the remainder of the certified stay. Based upon this cost relationship, the existing per diem payments made to these facilities were recalibrated to reflect a "step down" in payment after day 7. The two per diem rates, when paid for the entire 42 day average length of stay, will pay an average amount equal to previous payments to these facilities. Thus, the revision in payment methodology was designed initially to be revenue neutral while providing further incentives for cost containment.

2. For certified days of care in which the patient is awaiting transfer to a more medically appropriate treatment setting outside of the hospital inpatient facility, the Colorado maximum RCCF (Residential Child Care Facility) rate will initially be paid.

3. Effective December 15, 1989, these free-standing psychiatric hospital rates will be updated annually by the methodology outlined in number 3. in the Adjustments To The Payment Formula section above.

4. Effective July 1, 1989 Cedar Springs Psychiatric Hospital was terminated as a Colorado Medicaid provider. Effective December 8, 1990 La Plata Psychiatric Hospital became eligible for reimbursement as a Colorado Medicaid provider.

**Public Process for Hospital Rate-Setting**

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.